SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

COMMUNITY FIRST CHOICE Policy Manual	Section: FORMS
	Subject: Provider Prepared Standards

PURPOSE

The purpose of the Agency Based Provider Prepared Standards (SLTC-253) is to capture information about a provider agency's policy and procedure to ensure program compliance. Provider prepared standards are one component of provider agency quality assurance reporting. (Refer to CFC/PAS 610).

INSTRUCTIONS

1. Provider Information:

    a. Provider Name: Enter the name of the provider agency in the space provided.

    b. Region/Office: If the provider prepared standard report was completed for a specific region or office that the provider serves enter the location of the region or office.

    c. Person Completing Form: Enter the name of the staff person(s) who completed the document. If there is more than one person list all of the people.

    d. Title: List the title of every person who completed the document.

    e. Date Completed: Enter the date the document was completed.

    f. Date Submitted: Enter the date the document was submitted to the Regional Program Officer (RPO).

2. Standard One: Serious Occurrence Report (SOR)- Complete the provider prepared section for the following criteria:

    a. List of SOR Reported Outside Timeframe: Run the "SOR Provider Agency Detail Timeline Report" in QAMS for July 1-

December 31 and report the number of SOR your agency completed that did not meet the 10 working day criteria for submitting SOR.

b. Top Three SOR: Run an SOR Search for SOR from July 1-December 31 and click the report button. Determine the top three incident types by cause and subtype. Report the top three in each category.

c. Agency Action and Follow-Up: In the space provided describe how the provider agency will utilize information on the number of SOR that were reported outside the required timeframe and the most frequent SOR cause and incident type for quality improvement.

If an agency runs the SOR reports outlined above (2.a and 2.b.) and no SORs are reported in the last year the agency must use the space in the Agency Action and Follow-up to document agency policy and procedures to educate members/personal care attendants about the requirements for SOR reporting.

d. If the agency doesn't complete the Agency Action and Follow-up or the agency hasn't reported any SOR in the past year, the standard is unmet.

3. Standard Two and Three: Plan Facilitator and Nurse Supervision- Complete the provider prepared section for the following criteria:

a. Attach a current copy of the nurse supervisor(s) license.

b. List the full names of employee/contractors who performed the duties of a Plan Facilitator and/or nurse supervisor from July1-December 30. For each employee/contractor indicate the following information:

i. Role: By each person's name indicate the duties that the staff person performed- Plan Facilitator (PF), Nurse Supervisor (NS) or Both;

ii. Agency Verification: The staff/contract person must sign the box to verify that the person listed is free of the conflict of interest criteria outlined in policy (Refer to CFC/PAS 720);

iii. Number Years of Experience: Indicate the number of years of experience the person has in aging/disability

related arena;

iv. Certification Training Date: If the person is a Plan Facilitator indicate the date the PF was certified (Refer to CBS 1103)

v. Date First PCP Form Completed: If the person is a Plan Facilitator indicate the date the first PCP Form was completed

vi. Date NS Staff Trained: If the person performs nurse supervision duties indicate the date CFC/PAS training was provided by the agency to the staff person.

c. If any of the following occurs the criteria is unmet:

i. Person has less than one year experience in the aging/disability arena; or

ii. Date Plan Facilitator completed first PCP form is after the date the person was certified.

4. Standard Four: Member Survey- Complete the provider prepared section for the following criteria:

a. Member Survey- Attach a current copy of the member survey. If no survey is available the criteria is unmet.

b. Include the following information on the member survey:

i. Date Survey Distributed- Document the date the member survey was distributed to members;

ii. Number of Survey Distributed- Document the number of surveys that were distributed to members; and

iii. Response Rate Percent (%)- Calculate the number of surveys collected out of the total surveys distributed

c. Member Survey Summary and Future Action: In the space provided the provider agency must provide a written summary of the survey results and complete at least one SMART (specific, measurable, achievable, realistic and include timeframes) goal/action plan that is based on the survey summary.

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5. Standard Five: Provider Enrollment - Attach current documentation to verify the following criteria:

   a. General Liability Insurance- General liability insurance must include a minimum $1,000,000 per occurrence and $2,000,000 per aggregate;

   b. Motor Vehicle Liability Insurance-Split limits of $500,000 per person for personal injury and $100,.000 per accident occurrence for property damage; or combined single limits of $1,000,000 per occurrence to cover such claims as may be caused by any act, omission, or negligence of the provider or its agents, officers, representatives, assigns, or subcontractors;

   c. Unemployment Insurance Coverage; and

   d. Workers Compensation Coverage.

   e. If the provider agency does not have documentation that verifies current coverage for the criteria (a-d) the standard is unmet.

6. Standard 6: Agency Organization Structure-Complete the section for the following criteria:

   a. Submit a copy of the provider agency's organizational chart or a summary of the provider agency's organizational structure that identifies all of the staff who perform duties relevant to CFC/PAS.

   b. Staff Position and Responsibilities- In the table list the name of every person who performs key CFC/PAS responsibilities and indicate with an "x" whether they perform the following functions:

      i. Access to QAMS
         1. If a person has access to QAMS, identify the type of access the member has. For example:

a. Read-Only
b. Enter SOR
c. Respond to SOR
d. Respond to QAC
e. Run Reports

ii. Review and Sign Off on Service Delivery Records (SDR);

iii. Bill Medicaid Claims;

iv. Complete paperwork for intake, 180 day and annual visits;

v. Provider CFC/PAS training to other staff, members, workers, etc.; and

vi. Complete internal chart reviews for the Quality Assurance Report.

7. Standard 7: Personal Care Attendant Training Curriculum- complete the section for the following criteria:

a. Attach a copy of the of the agency's personal care attendant (PCA) training curriculum. The curriculum must identify the ten mandatory topic areas as outlined in CFC/PAS 706. For each topic area the curriculum must identify the following:

i. Training method;

ii. Length of time to cover topic;

iii. Person leading the training of the topic;

iv. Qualification of the trainer;

v. Evaluation method used to determine attendant competency with topic; and

vi. Role of Nurse Supervisor in overseeing the training of the topic and competency of member with topic.

vii. If the agency doesn't have a training curriculum that addresses the ten training topics and all of the items outlined above (7.a.i-vi), the criteria is unmet.

b. The provider agency must also document the process for

determining competency when the training requirement is waived. The competency determination must include the following:

i. Procedures and instruments for evaluating PCA competency;

ii. Established level of competency that must be achieved by PCA to qualify for waiver of training requirements;

iii. Plan for remedial basic training for a PCA who fails to meet level of competency;

iv. Mechanism for documenting successful demonstration of competency; and

v. Role of nurse supervisor in overseeing competency and waiver of training requirement.

vi. If the agency doesn't have a waiver of training policy that addresses all of the requirements outlined above (7.b.i-vi), the criteria is unmet.

8. Standard 8: PCA Training Certification- complete the section for the following criteria:

a. Select the last five PCAs who were hired to work with Medicaid CFC/PAS members and document the following for each PCA:

i. PCA Name- Provide the full name of the PCA;

ii. Hire date- Provide the date the PCA was hired;

iii. Date Training Completed/Waived- Provide the date the PCA completed training or the date the provider agency determined the PCA qualified for a waiver of training;

iv. Certification/Competency Date- Provide the date the PCA was certified (if completed training) or determined competent (if training was waived);

v. Name of first CFC/PAS Member Served- Provide the name of the first member that the PCA worked with; and

vi. First Day of Service with Member- Provide the date that the PCA first worked with the member.

9. Standard 9: PCA In-Service Training Requirement- Complete the section for the following criteria:

    a. Attach a copy of provider agency's policy addressing how PCA longevity is tracked and how the agency ensures that each PCA receives the required in-service training according to policy (Refer to AB CFC/PAS 706). The policy must include:

        i. Process to ensure that any PCA who receives a waiver of the training requirements completed mandatory 8 hours of in-service training within their first year of employment; and

        ii. Process to ensure that any PCA who completes the training curriculum receives mandatory 8 hours of in-service training within their second full year of employment.

    b. Pull a random sample of five PCAs who have worked more than two years with the agency. Attach a list of the five PCAs that include the following for each PCA:

        i. Name;

        ii. Type of training competency- select one of the two:

            1. Training; or
            2. Waiver of training.

        iii. If training was selected provide the following:

            1. Initial certification date.

        iv. If waiver of training was selected provide the following:

            1. Competency date; and
            2. Reason training was waived.

        v. List of in-service training completed in last two calendar years. List must include:

            1. Date completed;
            2. Topic; and
            3. Length of training in hours or minutes.

vi. Total in-service training completed in past two calendar years.

10. Standard 10: Agency Action Plan- Provider agency must submit a written action plan when any of the criteria from the agency's Provider Prepared Standards or Internal Quality Assurance Review standards are unmet.

    For each unmet criteria, the agency must complete a minimum of one Specific Measureable Action-specific Relevant and Time specific (SMART) goal to address the unmet criteria.

REPORTING TIMEFRAME

The Provider Prepared Standards must be submitted to the Regional Program Officer by April 1 of each year in conjunction with the Internal Quality Assurance Review (SLTC-252).

A provider agency that has enrolled as a Community First Choice/Personal Assistance Service provider agency in the past year or a provider agency that has extenuating circumstances and needs additional time to complete the Provider Prepared Standards, may request one three-month extension to complete the Provider Prepared Standards. A provider agency must submit the request for an extension in writing to the Regional Program Officer by March 15th.